



TOKIO MARINE
HCC

Stop Loss Claims & Notification Guide

For Specific and Aggregate Stop Loss

Tokio Marine HCC – A&H Group
A member of the Tokio Marine HCC Group of Companies
For producer use only. Not for public distribution.
Visit us online at tmhcc.com/AHGroup
TMHCC1347 - 09/2026
#TMHCC_AHGroup

Notice

This guide can be used as a reference when submitting potential claim notifications or stop loss reimbursement requests to Tokio Marine HCC – A&H Group.

Special Note

Nothing in this guide changes the terms of any stop loss policy. The stop loss policy language will take precedence if there is any conflict between this guide and the policy.

Contents

Specific Claim Notifications	Page 3
Notifications	Page 3
Catastrophic Claims	Page 3
Other Large Claims (50% of the Specific Deductible)	Page 3
Filing a Notification	Page 3
Reporting requirements	Page 3
Cost Containment	Page 4
Preliminary Claims Unit (PCU)	Page 4
Initiation of Cost Containment Process	Page 4
Negotiation for Simultaneously Funded Claims	Page 4
Bill Review for Reimbursement Requests	Page 5
Specialty Claims Unit (SCU)	Page 5

Contents (Continued)

Specific Claim Reimbursement Requests	Page 6
Filing Guidelines	Page 6
Filing a Reimbursement Request	Page 6
Filing Simultaneous Funding Request	Page 6
Reporting Requirements	Page 7
Aggregate Claim Reimbursement Requests	Page 8
Reporting Responsibilities	Page 8
Filing a Monthly Deductible Advance Reimbursement	Page 8
Year End Aggregate Claims	Page 9
Filing a Year End Aggregate Claim	Page 9
General Information	Page 10
Pre-Audit	Page 10
ACH Reimbursements	Page 10
Fees Reimbursable	Page 10
Repricing Fees	Page 10
Large Case Management (LCM) Fees	Page 10
Specialty Rx Fees	Page 10
Reference Based Pricing (RBP) Fees	Page 11
State Surcharges	Page 11
Fees not Reimbursable	Page 12
Administrative Fees	Page 12
Capitated Rates	Page 12
Administrative for LCM (large case management)	Page 12
Drug Card Administrative Fees Administrative	Page 12
Legal Matters/Complaints	Page 12
Subrogation/Third Party Liability	Page 12
Overpayments & Refunds	Page 13
Dental, Vision, Weekly Income & Prescription Drug Card Charges	Page 13
Eligibility Reference	Page 13
Employee/Member	Page 13
Dependents	Page 13
Additional Information Needed Based on Situation	Page 14
ICD Trigger List	Page 15

Specific Claim Notifications

Notifications

Utilization Review Vendors, Brokers and Claims Administrators will submit information to Tokio Marine HCC – A&H Group (TMHCC) regarding claimants with catastrophic conditions or claimants who have exceeded 50% of their specific deductible. The Claims Support Unit manages these early notifications. Once notification of a potentially large claim is received, TMHCC can begin managing the associated costs. This will also allow us to appropriately establish reserves in preparation for claim reimbursements.

There are several different types of notices, the ones that follow apply to claims review.

Catastrophic Claims

Conditions and procedures likely to exceed specific deductibles are outlined in the Trigger Diagnosis list. These conditions tend to be chronic, require extensive ongoing treatment, hospitalization, case management and/or high-cost medications.

Other Large Claims (50% of the Specific Deductible)

When a claimant reaches or has the potential to reach 50% of their specific deductible, notification should be submitted. This will allow us to appropriately establish reserves in preparation for claim reimbursements. Examples of instances that could exceed 50% of specific deductibles would be traumas, lengthy in-patient stays of 7 days or more, multiple admissions (3 in 2 months), surgery or complications of surgery.

See the [ICD Trigger Diagnosis List](#) for details.

Filing a Notification

Find notification forms on our website tmhcc.com/ahgroup

All completed forms should be submitted by secure email to stoplossnotifications@tmhcc.com

Reporting Requirements

The minimum requirements for notification include the following:

- Group Name
- Stop Loss Policy Effective Date
- Member Name
- Member Date of Birth
- Member Identification Number
- Claimant Name
- Claimant Date of Birth
- Primary Diagnosis
- Claims Paid to Date
- Claims pending

Providing additional details such as secondary diagnosis, prognosis, clinical updates, eligibility details and confinement dates are helpful and most appreciated.

Cost Containment

TMHCC is able to assist with managing the cost of claims in two ways. First, by putting contracted pricing in place prior to a high dollar medical event occurring. Second, by evaluating claims to verify what we pay is correct and without discrepant or egregious charges. Cost containment is a valueadded service that positively impacts our Policyholders.

Cost Containment is divided into the Preliminary Claims Unit (PCU) and the Specialty Claims Unit (SCU).

Preliminary Claims Unit (PCU)

The PCU team utilizes vendors that specialize in cost containment to impact claims.

TMHCC can identify potential cost containment opportunities for select claims that may include discrepant charges. This includes claims requesting simultaneous funding as well as high dollar claims that have been paid. Simultaneous funded claims will be evaluated by an outside vendor for facility negotiation resulting in a signed Letter of Agreement (LOA) between the facility and TMHCC. For reimbursement requests, where the facility has already been paid, the vendor will perform a bill review for discrepant charges. If discrepant charges are identified TMHCC will reimburse the requested amount minus the discrepant charges.

Initiation of Containment Process

A claim is identified for cost containment.

1. A Delay Letter is sent to the Claims Administrators (or appropriate party depending on Policyholder) indicating the claim will be evaluated for cost containment.
2. Correspondence requests response from Claims Administrators, or other, if cost containment is precluded based on a network agreement or other stipulation.
3. Needed documents are requested (IB/UB/payment methodology).
4. Once received, UB/IB/payment methodology are sent to a vendor for a pre-screen to identify potential billing errors or potential for negotiation with the facility.

Negotiation of Simultaneous Funded Claims

The vendor will negotiate directly with the facility to reduce payment due.

1. Vendor utilizes bill review, industry standards and the Plan Document to determine reason for reduction.
2. If successful, a Letter of Agreement (LOA) is obtained between TMHCC and the facility documenting acceptance of an agreed upon payment amount. This amount is paid to the Claims Administrators (or other) for facility payment. A copy of the LOA and an explanation letter is also provided.

Bill Review for Reimbursement Requests

The vendor will review claim for discrepant charges.

1. A bill review from the vendor is provided to TMHCC documenting discrepant findings.
2. This review is provided to the Claims Administrators (or other) along with a letter explaining that the requested reimbursement will be reduced by the amount of discrepant finding.
3. Discrepant amount is withheld from the reimbursement.
4. Claims Administrator (or other) will provide findings to facility and request an adjustment of previous payment. Documentation provided to the facility includes the right to appeal within 90 days. Appeals are requested in writing.

The vendors support all appeals and will respond in writing to the facility.

Specialty Claims Unit (SCU)

SCU is comprised of nurses that help with different types of claims.

Neonates – The SCU nurse focuses on neonates, a complex and costly component of healthcare. The nurse places reserves and sends claims to vendors for review or negotiation. This process is similar to that of PCU.

For transplants and other high dollar medical events, our nurses attempt to impact claims by intervening prior to the medical event occurring. This may include organ transplant, cancer care, immunotherapy, gene therapy, high dollar cardiac intervention (LVAD) or other procedures. SCU utilizes outside vendor contracts to mitigate cost. Vendors have negotiated pricing with various facilities that SCU can access for a fee. SCU will review available contracts for the specific high dollar event and facility to determine which contract offers the best potential for cost savings. If a contract is not available SCU will contact a vendor to place a Single Case Agreement (SCA) with the facility.



Specific Claim Reimbursement Requests

Filing Guidelines

Policies prior to 01/01/2025:

A complete claim request for reimbursement must be submitted within 90 days after the last date for which Plan Benefits can be reimbursed under the terms of the Policy. The failure to file a claim within 90 days may result in claims denial, whether or not the delay has prejudiced TMHCC.

Policies effective dates 01/01/2025 and after:

A notice of a claim must be submitted within 90 days after the last date for which Plan Benefits can be reimbursed under the terms of the Policy. The failure to submit a completed claim to TMHCC within 180 days, will be denied, whether or not the delay has prejudiced TMHCC.¹

Filing a Reimbursement Request

Once a claimant's eligible paid charges exceed the Specific Deductible the following items are needed:

Reimbursement Claim forms can be found on our website: www.tmhcc.com/AHGroup

All completed forms should be submitted via secure email to StopLossSpecClaims@tmhcc.com

Copy of member's enrollment card or Claims Administrators' eligibility screen prints including the hire date and the original effective date of coverage.

Refer to the Eligibility Reference sheet in addendum for additional information when applicable.

Filing Simultaneous Funding Requests

TMHCC recognizes that occasionally groups may have difficulty paying extremely large provider bills, especially when a prompt pay discount is involved. To assist in these situations, TMHCC offers a Simultaneous Funding option. This is a value-added service that provides cash-flow assistance in these instances. The Simultaneous Funding option can be changed or withdrawn at our discretion without prior notice. All Simultaneous Funding reimbursement requests will be processed in received date order. These requests will not be rushed or expedited, unless negotiated discounts are at stake and might be lost.

¹ Claims Filing provisions may vary by state. See policy for applicable requirements.

Filing Simultaneous Funding Requests (Continued)

The Simultaneous Funding Request form certifies the following:

- Prior to the expiration of the stop loss policy, the Claims Administrator processed all eligible bills related to the Simultaneous Funding request.
- Checks totaling at least the amount of the Specific Deductible were processed, paid, and released to the providers indicated, prior to the expiration of the stop loss policy, or prior to the Simultaneous Funding Reimbursement Request, whichever is earlier.
- The Plan Sponsor has unconditionally paid all other claims for the Claimant. Policies are written on a reimbursement basis only. This means, the Plan Sponsor is responsible for paying all eligible expenses. Subsequently, TMHCC processes requests for reimbursement of these expenses.
- The only mechanism that allows amendment of this provision to assist clients with payment of large medical charges is via our Simultaneous Funding option.
- TMHCC must receive written notice of Simultaneous Funding requests no more than (10) ten calendar days after the expiration date of the stop loss policy. Simultaneous Funding form must be completed for the claim request.
- Simultaneous Funding requests will not be accepted if received within (30) thirty days of the date of the Policy's cancellation or premature termination. For example, if a group's Policy Year runs from 4/01/23 – 3/31/2024 and the Policy is canceled prematurely on 12/31/2023, Simultaneous Funding requests would be prohibited beginning January 2024. Therefore, if requesting Simultaneous Funding, it is critical that all guidelines outlined above are adhered to otherwise, the reimbursement request could be denied.

NOTE: Reimbursement requests over \$750,000 requires additional leadership review.

Reporting Requirements

System generated reports, preferably in Excel, capturing all required data listed below will ensure the timely auditing of reimbursement requests.

- | | |
|-----------------------------|---------------------------|
| • Report Date | • Submitted/Billed Amount |
| • Policyholder | • Discount Amount |
| • Insured Name | • Ineligible Amount |
| • Employee Member ID Number | • Deductible Amount |
| • Claimant name | • Coinsurance Amount |
| • Service From Date | • Copayment Amount |
| • Service To Date | • Paid Amount |
| • Primary ICD-10 Code | • Payee Name |
| • CPT/Revenue/HCCPC Codes | • Provider Tax ID |
| • ICD-10 Procedure Codes | • Paid Date |

Aggregate Claim Reimbursement Requests

Reporting Responsibilities

Claims Administrators are required to report full aggregate claims data as soon as possible after the close of any calendar month. Information should include monthly and Year-To-Date claims summaries (i.e., census, paid amounts, ineligible claims, etc.). The report should indicate the appropriate contract dates and type of contract (e.g., "Paid," 12/15, etc.). Monthly reports should be submitted to stoplossaggregate@tmhcc.com Monthly Deductible Advance Reimbursement (MDAR) (Also known as Monthly Aggregate Accommodation).

Monthly Deductible Advance Reimbursement is offered as an option to our stop loss policies through an endorsement to the stop loss policy. Review the policyholder's Policy Endorsement for a complete list of requirements/qualifications.

The Monthly Deductible Advance Reimbursement is designed to assist the Policyholder with cash flow during the term of the contract. It does not replace the funding requirements. The plan sponsor, prior to receiving monthly accommodation, must pay all claims.

Filing a Monthly Deductible Advance Reimbursement

To file a Monthly Deductible Advance Reimbursement; please submit the following documentation:

- Completed Monthly Aggregate Accommodation Reimbursement Form.
- Monthly Loss Summary Reports showing the Policyholder's paid claims data and Aggregate census information as noted in section A.
- Paid Claims Analysis showing employee name, claimant name, service date, type of service, amount of charges and amount paid.

Please Note the Following:

- **Monthly Deductible Advance Reimbursement** it is preferred we receive within 15 days following the end of the month for which the accommodation is requested. For example, if you are filing for the month of June, then it is preferred we receive your request no later than July 15.
- **Monthly Deductible Advance Reimbursement** is not available in the last month of the contract or during a run-out provision. Please refer to the Policy Endorsement for further clarification.

If Year-To-Date claims fall below the accumulated aggregate deductible in a given month, all accommodation payments must be refunded in the following month. If the Policyholder has not incurred an aggregate claim at the end of the contract year, TMHCC must be refunded all Monthly Deductible Advance Reimbursement payments at contract termination/expiration.

Year End Aggregate Claims

Policies prior to 01/01/2025:

Reimbursement requests must be filed within 90 days after the end of the time specified for payment of claims under the stop loss policy. Failure to do so may result in claim denial.

Policies effective dates 01/01/2025 and after:

A notice of a claim must be submitted within 90 days after the last date for which Plan Benefits can be reimbursed under the terms of the Policy. The failure to submit a completed claim to TMHCC within 180 days, will be denied, whether or not the delay has prejudiced TMHCC.²

Filing a Year End Aggregate Claim

To file a year-end aggregate claim, please submit the following documentation for your contract period to stoplossaggregate@tmhcc.com

- Completed Year End Aggregate Claim Form. Paid Claims Analysis report indicating claimant's name, incurred date, charged amount, paid amount and paid date
- Eligibility listing which identifies birth date, effective date, termination date and coverage type.
- Proof of funding to include bank statements and/or deposit slips.
- Void & Refund report.³
- Benefit/Service Code report.
- Aggregate report (Monthly Loss Summary Reports)
- Specific report- showing claimants that have exceeded the Specific Deductible/Loss Limit
- Listing of payments made outside the Aggregate contract (i.e., Dental, Weekly Income, Vision, PPO Fees-capitated, PCS Administrative Fees)
- Check Register
- Outstanding overpayment and subrogation log
- Rx invoices if Rx is covered under the Aggregate contract.

² Claims Filing provisions may vary by state. See the policy for applicable requirements.

³ Information is also requested the month following expiration of the stop loss contract review for retroactive adjustments.

General Information

Pre-Audit

Our Pre-Audit team is comprised of experienced stop loss auditors. This team reviews initial filings for reimbursement to determine if a claim submission is complete or if additional information is needed such as eligibility information, accident details, etc. This preliminary review of eligibility on the initial submission, benefits Claim Administrators, and Producers by ensuring all necessary information to reimburse the claim has been received prior to the specific claim auditor's review.

Having a Pre-Audit team expedites claim reviews and limits the number of auditors reaching out for eligibility. Also, it builds interpersonal relationships between the Pre-Audit team, Claims Administrators and Producers, and can help to reduce the claims reimbursement turnaround time.

For additional efficiencies, we have created a centralized email address to be used when corresponding with our Pre-Audit team, claimspreadit@tmhcc.com.

ACH Reimbursements

TMHCC offers Automated Clearing House (ACH) for claim reimbursements for faster reimbursement.

When you enroll in our ACH program, you will receive reimbursements in your designated bank account within 48 hours of transfer.

For additional information on the ACH Enrollment Process, please reach out to our ACH Enrollments team at hcclachenrollments@tmhcc.com

Fees Reimbursible

Cost containment is an essential function in our industry. Each section below outlines which costs associated with these functions are reimbursed under the stop loss policy.

Savings Fees

TMHCC will reimburse cost containment savings fees up to a maximum of 25% of the savings, up to a maximum of \$50,000 per claimant per year when the claim exceeds the Specific Deductible.

Large Case Management (LCM) Fees

Proper management results in savings and the cost of that management are reimbursable under the stop loss policy provided the claim payments, in addition to the LCM fees, exceed the Specific Deductible and those fees are Incurred and Paid in accordance with the Policy's Contract Basis. A copy of LCM reports should be submitted when requesting TMHCC to reimburse LCM fees.

Fees Reimbursible (Continued)

Specialty Rx Fees

TMHCC has developed a review process with a list of accepted vendors for this Specialty Rx service. Each vendor offers a variety of programs with unique pricing fees. It is important that you inform TMHCC of the vendor you have selected to ensure it is on the list of accepted vendors and if any portion of the fees would be covered. For additional information on Specialty Rx Fees, please reach out to Valerie Suarez vsuarez@tmhcc.com

Reference Based Pricing (RBP) Fees

TMHCC has developed a review process with a list of accepted vendors for this RBP service. Each vendor offers a unique program with different pricing fees. It is important that you inform TMHCC of the RBP vendor you have selected to ensure it is on the accepted list and if any of the fees would be covered. For additional information on Reference Based Pricing (RBP) Fees, please reach out to Valerie Suarez vsuarez@tmhcc.com

State Surcharges

Certain states levy surcharges on in-patient and outpatient hospital bills for uncompensated care pools, training, etc. Certain state surcharges (For example, New York) where the courts have ruled that ERISA does not prevent the imposition of the state surcharge.



Fees Not Reimbursable

Administrative Fees

Claims Administrators will review and make determinations associated with their role as administrator in the adjudication of claims on behalf of the plan. Examples of these fees include activities such as Claims Administrator initiated medical reviews, medical record fees, reasonable and customary (R&C) determinations, procedure reviews, experimental/investigation reviews, PPO access fees, Pay for Performance (P4P), or custodial care reviews. These fees are not eligible under the Specific or Aggregate stop loss coverage.

Capitated Rates

Capitated rates are billed at a flat rate per employee per month and are not eligible under the Specific or Aggregate stop loss coverage.

Administrative Fees for Large Case Management (LCM)

Administrative fees for LCM (large case management) are considered operational/administrative functions and include the cost for sending e-mails, faxes, eligibility determination, clerical fees, or capitated fees that are charged to the group as per member, per month fees. Large case management, as we understand it, is directly associated with the management of an ongoing catastrophic claim. These fees are not eligible for reimbursement under the Specific or Aggregate stop loss coverage.

Drug Card Administrative Fees

Drug Card Administrative Fees for Drug Card programs are not eligible for reimbursement under the Specific or Aggregate stop loss coverage.

Legal Matters/Complaints

TMHCC should be advised immediately by email of any legal matter in which TMHCC is named. The summons and complaint, along with the complete file and any supplemental documentation, should be forwarded to the Compliance Department in the Kennesaw, GA office.

TMHCC should be advised immediately of any lawsuit in which TMHCC is not named but could become involved because of Specific or Aggregate stop loss coverage. The complete file and any supplemental documentation should be forwarded to us for review.

TMHCC must be advised of all Insurance Department Complaints in which our coverage is involved. The original complaint and complete claim file should be forwarded to us for our immediate review. Please email them to our Compliance Department at hcclcompliance@tmhcc.com

Subrogation/Third Party Liability

Subrogation/Third Party Liability involves situations where a claimant incurs medical expenses that have been caused by a third party. It provides the Plan and the Policyholder with an opportunity to shift the costs of the claimant's medical care onto the responsible party (their insurance company or other responsible entity).

Subrogation/Third Party Liability (Continued)

For us to consider reimbursement on cases involving subrogation/third party liability, we must first have the following documentation:

- Completed Liability Questionnaire Attachment B: Accident Liability Form or the claims administrator's form with supporting attachments.

Overpayments & Refunds

All refunds should be forwarded to our Kennesaw, GA office if the overpayment pertains to a specific or aggregate claim payment. Please include policy and claimant(s) name when sending in a refund.

Please be aware that refunds are often received after the policy year has expired. Even so, if the overpayments apply to the Incurred and Paid dates of the specific and/or aggregate coverage and if reimbursement claims have been paid, these refunds may rightfully belong to TMHCC.

Dental, Vision, Weekly Income & Prescription Drug Card Charges

Stop loss policies are written to suit the individual needs of each Policyholder. Therefore, not all contracts include the same types of coverage. To know exactly which coverage options the Policyholder has elected, please review the Policyholder's Application for complete details.

Eligibility Reference

Our goal is to provide prompt and accurate reimbursement of claims. Below is a reference for better understanding when additional questions might occur. This document is not all-inclusive, and some situations may require further information or clarification.

Employee/Member

Active Employees/Members:

- Enrollment: Must include date of hire and the original effective date (the date the employee originally had medical coverage with the group).
- Work Status: Completed work status form showing last date worked, return to work and how coverage was continued when employee/ member was not physically working.
- Was he/she on FMLA? (If intermittent, list dates and hours used).
- Did he/she use Short-Term or Long-Term Disability? (Policy or Handbook should be submitted).
- Did he/she elect COBRA? - Election form and verification of premiums required.

Retirees: If the medical stop loss policy reimburses for retiree coverage, medical premium verification will be requested.

Dependents

Spouse

- Enrollment: For both the employee/member and spouse (must include original effective date of medical coverage with the group).
- Work Status of Employee: If the claim filing is on a dependent spouse, and the employee/member is 65 years of age or older, work status on the employee/member may be requested if the dependent has an extended illness or multiple confinements.
- COB: Does the spouse have any other coverage? Note: The date of verification should be within 12 months of the claim incurred date.

Child

- Enrollment: For both employee/member and child (must include original effective date of medical coverage with the group).
- Work Status of Employee: If the claim filing is on a dependent child, work status on the employee/member may be requested if the dependent child has an extended illness or multiple confinements.
- COB: Does the child have any other coverage? Note: The date of verification should be within 12 months of the claim incurred date.
- Newborn:
 - Timely Enrollment: Verification of the date that the employee asked to add the newborn to the policy. Note: Most plan documents state that the employee has 31 days to add from the date of birth.
 - Work Status of Employee: If the claim filing is for a newborn child, work status on the employee/member may be

Additional Information Needed Based on Situation

Accident Questionnaire: Info is required when there has been an accident/injury paid over \$5,000.00.

Americans with Disabilities Act (ADA): We request signed paperwork and estimated return to work date.

Dialysis: First date of dialysis is required.

Leave Policies:

- Short-Term Disability Policy (STD)
- Long-Term Disability Policy (LTD) - Premium verification requested
- Group's Leave of Absence Policy (LOA) - Premium verification requested if documented in the Plan Document
- Employee Handbook

ICD Trigger List

Suggested Categories and Guidelines for Identifying Potential Catastrophic Claims

The ICD-10 codes and diagnoses listed below are key indicators of potential catastrophic claims. Codes should be referred and or disclosed to Tokio Marine HCC – A&H Group.

<u>A00-B99</u>	<u>Certain infectious and parasitic disease</u>	<u>J00-J99</u>	<u>Diseases of the respiratory system</u>
A40	Streptococcal sepsis	J40-J44	Chronic Obstructive Pulmonary Disease (COPD)
A41	Other sepsis	J84	Other interstitial pulmonary diseases
B15-B19	Viral hepatitis	J98	Other respiratory disorders
<u>C00-D49</u>	<u>Neoplasms</u>	<u>K00-K95</u>	<u>Diseases of digestive system</u>
C00-C96	Malignant neoplasms	K50	Crohn's disease
D3A	Benign neuroendocrine tumors	K51	Ulcerative colitis
D42-D43	Neoplasm of uncertain behavior of meninges, brain & central nervous system	K70-K77	Diseases of liver
D46	Myelodysplastic syndromes	K83	Diseases of biliary tract
		K85-K86	Diseases of pancreatitis
<u>D50-D89</u>	<u>Diseases of the blood/blood-forming organs & disorders involving the immune mechanism</u>	<u>L00-L99</u>	<u>Diseases of the skin & subcutaneous tissue</u>
D55-D59	Hemolytic anemias	L40	Psoriasis
D60-D64	Aplastic and other anemias	L51	Erythema multiforme
D65-D69	Coagulation defects, purpura and other hemorrhagic conditions	<u>M00-M99</u>	<u>Diseases of musculoskeletal system & connective tissue</u>
D70-D77	Other diseases of blood and bloodforming organs	M05-M06	Rheumatoid arthritis
D80-D89	Certain disorders involving the immune mechanism	M1A	Chronic gout
<u>E00-E89</u>	<u>Endocrine, nutritional and metabolic diseases</u>	M10.0	Idiopathic gout
E23.0	Hypopituitarism	M15-M19	Osteoarthritis
E30	Disorders of puberty, not elsewhere classified	M30-M35	Systemic connective tissue disorders
E34	Other endocrine disorders	M41	Scoliosis
E70-E89	Metabolic disorders	M43	Spondylolysis
		M50	Cervical disc disorders
		M5	Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders
<u>G00-G99</u>	<u>Diseases of the nervous system</u>	M72.6	Necrotizing fasciitis
G00-G09	Inflammatory diseases of the central nervous system	M86	Osteomyelitis
G10-G13	Systemic atrophies primarily affecting the CNS	<u>N00-N99</u>	<u>Diseases of the genitourinary system</u>
G35	Multiple sclerosis	N01	Rapidly progressive nephritic syndrome
G36	Other acute disseminated demyelination	N03	Chronic nephritic syndrome
G37	Other demyelinating disease of central nervous system	N04	Nephrotic syndrome
G47.4	Narcolepsy and cataplexy	N05-N07	Nephritis and nephropathy
G61	Inflammatory polyneuropathy	N08	Glomerular disorders classified elsewhere
G70	Myasthenia gravis & other myoneural disorders	N17	Acute kidney failure
G71	Primary disorders of muscles	N18	Chronic Kidney Disease (CKD)
G73.1	Lambert-Eaton syndrome in neoplastic disease	N19	Renal failure, Unspecified
G93.1	Anoxic brain injury	<u>O00-O09A</u>	<u>Pregnancy, childbirth and the puerperium</u>
<u>H00-H59</u>	<u>Diseases of the eye and adnexa</u>	O09	Supervision of high risk pregnancy
H35.5	Hereditary retinal dystrophy	O10-O16	Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
H35.50	Unspecified hereditary retinal dystrophy	O30-O48	Maternal care related to the fetus and amniotic cavity and possible delivery problems
<u>I00-I99</u>	<u>Diseases of circulatory system</u>	O60.1	Preterm labor with preterm delivery
I12	Hypertensive chronic kidney disease	O69	Labor and delivery complicated by umbilical cord complications
I13	Hypertensive heart and chronic kidney disease		
I20-I25	Ischemic heart diseases		
I27	Other pulmonary heart disease		
I28	Other diseases of pulmonary vessels		
I30-I52	Other forms of heart disease		
I60-161	Subarachnoid hemorrhage / Intercerebral hemorrhage		
I63	Cerebral infarction		
I65.8-I66	Occlusion of precerebral /cerebral arteries		
I67	Other cerebrovascular disease		
I70	Atherosclerosis		
I71	Aortic aneurysm & dissection		
I81	Portal vein thrombosis		
I85	Esophageal varices		

ICD Trigger List (Continued)

P00-P96	<u>Certain conditions originating in the perinatal period</u>	T30-T32	<u>Burns and corrosions of multiple body regions</u>
P07	Disorders of newborn related to short gestation and low birth weight	T78.3	Angioneurotic Edema
P10- P15	Birth trauma	T81.11-T81.12	Postprocedural cardiogenic and septic shock
P19-P29	Respiratory & cardiovascular disorders specific to the perinatal period	T82	Complications of cardiac and vascular prosthetic devices, implants and grafts
P36	Bacterial sepsis of newborn	T83-T85	Complications of prosthetic devices, implants and grafts
P52-P53	Intracranial hemorrhage of newborn	T86	Complications of transplanted organs and tissue
P56	Hydrops fetalis due to hemolytic disease	T87	Complications to reattachment and amputation
P77	Necrotizing enterocolitis of newborn		
P91	Other disturbances of cerebral status newborn		
		U00-U85	<u>Codes for special purposes</u>
		U07.1	COVID-19
Q00-Q99	<u>Congenital malformations, deformations and chromosomal abnormalities</u>	Z00-Z99	<u>Factors influencing health status and contact with health services</u>
Q00-Q07	Congenital malformations of the nervous system	Z37.5-Z37.6	Multiple births
Q20-Q28	Congenital malformations of the circulatory system	Z38.3-Z38.8	Multiple births
Q41-Q45	Congenital anomalies of digestive system	Z48.2-Z48.298	Encounter for aftercare following organ transplant
Q60	Renal agenesis and other reduction defects of kidney	Z49	Encounter for care involving renal dialysis
Q79	Congenital malformations of the musculoskeletal system	Z51.0	Encounter for antineoplastic radiation therapy
Q85	Phakomatoses, not classified elsewhere	Z51.1	Encounter for antineoplastic chemotherapy and immunotherapy
Q87	Congenital malformation syndromes affecting multiple systems	Z92.85	Personal history of CAR T-cell therapy
Q89	Other congenital malformations	Z92.86	Personal history of gene therapy
		Z94	Transplanted organ and tissue status
		Z95	Presence of cardiac and vascular implants and grafts
R00-R99	<u>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</u>	Z98.85	Transplanted organ removal status
R18	Ascites	Z99.1	Dependence on respirator
R57-R58	Shock, hemorrhage	Z99.2	Dependence on dialysis
R65	Symptoms & signs specifically associated with systemic inflammation and infection		
S00-T88	<u>Injury, poisoning and certain other consequences of external causes</u>		
S02	Fracture of skull and facial bones		
S06	Intracranial injury		
S07	Crush injury to head		
S08	Avulsion and traumatic amputation of part of head		
S12-S13	Fracture and injuries of cervical vertebra and other parts of neck Injury of nerves and spinal cord at neck level		
S14.0-S14.15	Injury of nerves and spinal cord at neck level		
S22.0	Fracture of thoracic vertebra		
S24	Injury of nerves and spinal cord at thorax level		
S25	Injury of blood vessels of thorax		
S26	Injury of heart		
S32.0	Fracture of lumbar vertebra		
S34	Injury of lumbar and sacral spinal cord and nerves		
S35	Injury of blood vessels at abdomen, lower back and pelvis		
S36-S37	Injury of intra-abdominal organs		
S48	Traumatic amputation of shoulder and upper arm		
S58	Traumatic amputation of elbow and forearm		
S68.4-S68.7	Traumatic amputation of hand at wrist level		
S78	Traumatic amputation of hip and thigh		
S88	Traumatic amputation of lower leg		
S98	Traumatic amputation of ankle and foot		

Additional disclosure information to be referred to Tokio Marine HCC – A&H Group

- Transplants – Transplants should be referred to our Specialty Claims Unit (SCU) for cost containment assistance prior to transplantation
- Pre-certifications and utilization reviews
- Rx Prescription Drugs and Specialty Drugs
- Large Case Management – LCM reports
- Specific claims at 50% of group deductible